Blue Precision Gold HMO℠ 101

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016-12/31/2016

Coverage for: Individual/Family | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsil.com/member/policy-forms/2016/36096IL0810037-00.pdf or by calling 1-800-538-8833.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual: Participating **$1,750** Family: Participating **$5,250** Doesn't apply to preventive care & certain copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Individual: Participating **$3,500** Family: Participating **$10,500**	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbsil.com or call **1-800-538-8833** for a list of Participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. All specialist visits require a written PCP referral unless it's for an OB/GYN or for emergency care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- The plan may encourage you to use Participating **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	Not Covered	Services or supplies that are not ordered by your Primary Care Physician or Women's Principal Health Care Provider, except emergency and routine vision exams, are not covered.
	Specialist visit	$50 copayment/visit	Not Covered	Referral Required.
	Other practitioner office visit	$50 copayment/visit	Not Covered	Referral Required. Acupuncture not covered. Chiropractic and Osteopathic Manipulation are limited to 25 visits per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	$50 copayment/visit	Not Covered	Referral Required
	Imaging (CT / PET scans, MRIs)	$250 copayment/visit	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_IL_5T_EX.pdf	Formulary generic drugs	No Charge	Not Covered	Retail covers a 30 day supply and home delivery covers a 90 day supply. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Generic drugs are not subject to the deductible.
	Non-formulary generic drugs	20% coinsurance	Not Covered	
	Formulary brand drugs	20% coinsurance	Not Covered	
	Non-formulary brand drugs	30% coinsurance	Not Covered	
	Specialty drugs	40% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copayment/visit plus 20% coinsurance	Not Covered	Referral required. Abortions not covered, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.
	Physician/surgeon fees	$50 copayment/visit	Not Covered	
If you need immediate medical attention	Emergency room services	$600 copayment/visit plus 20% coinsurance	$600 copayment/visit plus 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	$25 copayment/visit	Not Covered	Must be affiliated with member's chosen medical group or referral required.
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copayment/day	Not Covered	Referral required. Copayment applies per day until the Out-of-Pocket limit has been met.
	Physician/surgeon fee	No Charge	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copayment/visit or 20% coinsurance	Not Covered	Referral required.
	Mental/Behavioral health inpatient services	$400 copayment/day	Not Covered	Referral required. Copayment applies per day until the Out-of-Pocket limit has been met.
	Substance use disorder outpatient services	$25 copayment/visit or 20% coinsurance	Not Covered	Referral required.
	Substance use disorder inpatient services	$400 copayment/day	Not Covered	Referral required. Copayment applies per day until the Out-of-Pocket limit has been met.
If you are pregnant	Prenatal and postnatal care	$25 copayment	Not Covered	Copyament applies to first prenatal visit per pregnancy.
	Delivery and all inpatient services	$400 copayment/day	Not Covered	Referral required. Copayment applies per day until the Out-of-Pocket limit has been met.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Referral required.
	Rehabilitation services	$50 copayment/visit	Not Covered	
	Habilitation services	$50 copayment/visit	Not Covered	
	Skilled nursing care	20% coinsurance	Not Covered	
	Durable medical equipment	20% coinsurance	Not Covered	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	20% coinsurance	Not Covered	Referral required.
If your child needs dental or eye care	Eye exam	No Charge	Covered	One visit per year. Reimbursed up to $30 out-of-network. See benefit booklet for network details.
	Glasses	Covered	Covered	One pair of glasses per year. Reimbursed up to $45 out-of-network. See benefit booklet for network details.
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (Limited to 25 visits per calendar year.)
- Cosmetic surgery (Only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (Two covered every 36 months for children or bone anchored)
- Infertility treatment
- Private-duty nursing (With the exception of inpatient private duty nursing)
- Routine eye care (Adult)
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-538-8833. You may also contact your state insurance department at 1-877-527-9431.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-538-8833.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-538-8833.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-538-8833.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-538-8833.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,040
- **Patient pays** $3,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,200
Copays	$200
Coinsurance	$900
Limits or exclusions	$200
Total	**$3,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,390
- **Patient pays** $2,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,800
Copays	$30
Coinsurance	$100
Limits or exclusions	$80
Total	**$2,010**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Blue Precision Gold HMO 101
Blue Precision HMO[SM] Network

OUTLINE OF COVERAGE

1. READ YOUR POLICY CAREFULLY. — This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. Blue Precision HMO – Blue Precision HMO provides, to persons insured, coverage for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services and Out-of-Hospital care, subject to any deductibles, Copayments or other limitations which may be set forth in your Policy. **The services you receive under the Policy must be provided by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider.** To receive benefits for treatment from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider. The referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

BASIC PROVISIONS	**Blue Precision Gold HMO 101**
	YOUR COST
Deductible Per individual, per calendar year	$1,750*
Family Aggregate Deductible Per family, per calendar year	$5,250*
Out-of-Pocket Expense Limitation*	
Individual	$3,500
Family	$10,500
PHYSICIAN BENEFITS	
Outpatient Physician office visits *(except for Outpatient periodic health examinations, routine pediatric care, routine vision examinations, chiropractic and osteopathic manipulations and maternity services after the first pre-natal visit)*	$25 per Visit
Outpatient Specialist office visits	$50 per Visit
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or dollar maximum: Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual	None

involved; evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).	
Outpatient Occupational, Physical and Speech Therapy Treatments	$50 per Treatment
Outpatient Surgery	$50 per Visit
Outpatient Diagnostic Services	$50 per Procedure
Computerized Tomography (CT scan), Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET scan)	$250 per Procedure
Outpatient Office Visits for the Treatment of Mental Illness Other Than Serious Mental Illness When Not Authorized by Primary Care Physician or Woman's Principal Health Care Provider	50% Coinsurance per Visit, after the program deductible
HOSPITAL BENEFITS	
Inpatient Hospital Copayment	$400 per Day
Inpatient Treatment of Mental Illness Other than Serious Mental Illness When Not Authorized by Primary Care Physician or Woman's Principal Health Provider	50% Coinsurance, after the program deductible
Outpatient Surgery Copayment	$200 per Visit, then subject to a Coinsurance of 50%, after the program deductible
Outpatient Infusion Therapy	40% Coinsurance, after the program deductible
All Other Outpatient Covered Services	20% Coinsurance, after the program deductible
SUPPLEMENTAL BENEFITS	
Supplemental Benefits Blood and blood components; Outpatient Private Duty Nursing, medical and surgical dressings, supplies, casts and splints, oxygen and its administration, naprapathic services prosthetic devices, orthotic devices and durable medical equipment	20% Coinsurance, after the program deductible
EMERGENCY CARE SERVICES BENEFITS	
Emergency Care Services (In-Area or Out-of-Area)	$600 deductible per Visit, then subject to a Coinsurance of 20%, after the program deductible *(deductible waived if admitted to Hospital as an Inpatient immediately following emergency treatment)*

Emergency Ambulance Transportation	20% Coinsurance, after the program deductible
SUBSTANCE USE DISORDER BENEFITS	
Inpatient Hospital Copayment for Substance Use Disorder Treatment	$400 per Day
Copayment for Outpatient office visits for Substance Use Disorder Treatment	$25 per Visit
Copayment for Outpatient specialist office visits for Substance Use Disorder Treatment	$25 per Visit
OUTPATIENT PRESCRIPTION DRUG PROGRAM	
30-Day Supply Outpatient Prescription Drug Program	
Formulary Generic Drugs, other than Specialty Drugs, and Formulary Generic Diabetic Supplies and insulin and insulin syringes	None
Non-Formulary Generic Drugs, other than Specialty Drugs, and Non-Formulary Generic Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible
Formulary Brand-name Drugs, other than Specialty Drugs, and Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible
Formulary Brand-name Specialty Drugs and Non-Formulary Brand-name Drugs and Non-Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	30% of the Eligible Charge per Prescription, after the program deductible
Non-Formulary Brand-name Specialty Drugs and insulin and insulin syringes	40% of the Eligible Charge per Prescription, after the program deductible
90-Day Supply Outpatient Prescription Drug Program	
Formulary Generic Drugs and Formulary Generic Diabetic Supplies and insulin and insulin syringes	None
Non-Formulary Generic Drugs and Non-Formulary Generic Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible
Formulary Brand-name Drugs and Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible
Non-Formulary Brand-name Drugs and Non-Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	30% of the Eligible Charge per Prescription, after the program deductible

DEPENDENT LIMITING AGE	
Limiting Age for Dependent Children *(regardless of presence or absence of child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of these factors).*	26
PEDIATRIC VISION CARE SERVICES	
Exams, Lenses, Frames and Contact Lenses	None
Low vision services and Laser vision correction Surgery (Lasik)	Traditional and custom Lasik Surgery will be provided at a discount from Participating Physicians and affiliated laser centers.

* The program deductible and Out-of-Pocket Expense Limitation amounts may be subject to change or increase as permitted by applicable law.

GUARANTEED RENEWABILITY

Coverage under the Policy will be terminated for nonpayment of premiums. Blue Cross and Blue Shield may terminate or refuse to renew the Policy only for the following reasons:

1. If every Policy that bears the Policy form number, is not renewed. If every Policy that bears the same Group Number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
   c. If Blue Cross and Blue Shield should terminate or refuse to terminate the Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinue all health care coverage and does not renew all health insurance Policies it issues or delivers for issuance in the individual market in the state. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of the Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice.
4. You no longer reside, live or work in the Blue Cross and Blue Shield's service area.
5. Failure to pay your premium in accordance with the terms of the Policy.

Blue Cross and Blue Shield will never terminate or refuse to renew the Policy because of the condition of your health.

EXCLUSIONS AND LIMITATIONS:

Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, HOSPITAL BENEFITS section and for Mental Illness (other than Serious Mental Illness) or for routine vision examinations, PHYSICIAN BENEFITS section of the Policy.

Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.

Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. Ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that Blue Cross and Blue Shield has provided benefits for the services or supplies rendered in connection with such injury.

Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature, except as specifically provided for in the Policy for a) the cost of routine patient care associated with Experimental/Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under the Policy if not provided in connection with an Approved Clinical Trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service.

Long Term Care Services.

Respite Care Services, except as specifically mentioned under Hospice Care Benefits section of the Policy.

Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Special education therapy such as music therapy or recreational therapy, except as specifically provided for in the Policy.

Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.

Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.

Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated in the Policy.

Prosthetic devices, special appliances or surgical implants unrelated to the treatment of disease or injury, for cosmetic purposes or for the comfort of the patient.

Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements, except as stated in your Policy.

Blood derivatives which are not classified as drugs in the official formularies.

Hypnotism.

Inpatient Private Duty Nursing Service.

Routine foot care, except for persons diagnosed with diabetes.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically stated in the Policy.

Maintenance Care.

Self-management training, education and medical nutrition therapy, except as specifically stated in the Policy.

Residential Treatment Centers, except for Inpatient Substance Use Disorder Treatment or Inpatient Mental Illness (other than Serious Mental Illness), as specifically mentioned in the Policy.

Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in the Policy.

Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in the Policy.

Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

Services or supplies rendered for human organ or tissue transplants except as specifically provided for in the Policy.

Wigs (also referred to as cranial prostheses).

Services or supplies rendered for infertility treatment, except as specifically provided for in the Policy.

Eyeglasses, contact lenses and/or hearing aids, except as specifically provided for in the Policy.

Acupuncture.

Reversal of vasectomies.

Services and supplies rendered or provided outside of the United States, if the purpose of the travel to the location was for receiving medical services, supplies or drugs.

Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in your Policy.